State of Florida
Department of Children and Families

Rick Scott
Governor

David E. Wilkins
Secretary

DATE: June 26, 2012

TO: Keith Perlman, Statewide Child Fatality Prevention Specialist

FROM: Lisa Rivera, M.S.W., Operations Review Specialist

SUBJECT: Death Review on Sean McKee

Attached is the limited death review on Sean McKee. If you have any questions, you can reach me at (813) 558-5614.

cc: Mike Carroll, Regional Director
Jan Gregory, Deputy Regional Director / Acting Community Development Administrator
Lisa Mayrose, Regional Family and Community Services Program Chief
Kathy Newcomb, Regional Program Administrator
Peggy Niermann, Regional Quality Assurance Manager
Beth Pasek, Senior Management Analyst
Brena Slater, Community Development Administrator
Rebecca Kapusta, Regional Chief Legal Council
A. Bronwyn Stanford, Children's Legal Services Regional Director
Maureen Coble, Director of Quality Management Services, Safe Children Coalition

LIMITED CHILD DEATH REVIEW FINAL REPORT

Child's Name: Sean McKee **Region/Circuit/County:** SCR/Circuit 12/Sarasota
Date of Birth: 02/02/11 **Date of Death:** 02/25/12 **Report Number:** FSFN 2012-046042

I. SUMMARY OF CHILD DEATH INVESTIGATION

A. Power Foster Home Household Composition.

Name	DOB or Age at Time of Incident	Relationship with Deceased Child*	Responsible Caregiver for Abuse/Neglect (Y/N)
Sean McKee	02/02/11 Age 1 year	Deceased Child	
[redacted]	Age 6 months	Foster Child	
[redacted]	Age 3 ½ years	Foster Child	
[redacted]	Age 5 ½ years	Foster Child	
[redacted]	Age 6 years	Adopted Child	
[redacted]	Age 7 ½ years	Adopted Child	
[redacted]	Age 8 ½ years	Adopted Child	
[redacted]	Age 16 ½ years	Biological Child of Cathy Power	
Cathy Power	01/28/69 Age 43 years	Foster Mother	Y - Neglect
Edmund Power	06/22/43 Age 68 years	Foster Father	Y - Neglect

B. Circumstances Surrounding Death. On 02/25/12, FSFN 2012-046042 was received in Sarasota County and indicated that 1-year-old Sean McKee was found face-down by the steps of the swimming pool at his licensed foster home. Sean had been placed in the Power foster home after having been removed from his mother following his birth due to substance abuse issues.

Initially, Sean was believed to be deceased and was pronounced dead after an hour of resuscitation efforts performed by the paramedics and hospital staff. However, once resuscitation efforts ceased and death was pronounced, Sean began breathing on his own. Given the critical nature of his condition, Sean was Bayflighted to All Children's Hospital where he was placed on life support. Although Sean was reported to be physically "stable", medical providers indicated that he was not responding neurologically and, therefore, a neurologist would be evaluating the situation.

Interviews conducted with the foster parents, Cathy and Edmund Power (ages 43 and 68 years, respectively), and the older foster children in the home were consistent with regards to the circumstances surrounding the incident. According to all, the older children had been out swimming the day prior. All of the children reported that their foster mother, Mrs. Power, was always nearby watching them whenever they were in the swimming pool even though they all knew how to swim; and if one of the younger children was in the pool then either Mr. or Mrs. Power was in the water with them.

When they finished swimming on 02/24/12, the protective barrier / fence around the pool was not put back up. The following morning, everyone was getting ready to go to a baseball game. The older kids were in the kitchen eating their breakfast while Mrs. Power took Sean out of his play pen and brought him to the foster parents' bedroom where Mr. Power was located. Mrs. Power then returned to the kitchen to ensure that the other children were eating and to given them their medication. Everyone acknowledged that the sliding doors leading out to the back were open and that somehow, they lost track of Sean. Mrs. Power believed that Sean was with her husband and Mr. Power believed that Sean was with his wife. Once Sean was observed floating in the swimming pool, 9-1-1 was called and efforts to resuscitate were initiated.

On 02/26/12, medical personnel reported that Sean's pupils were "blown" and he was referred for a brain-death study. Sean failed the first of two assessments and a second assessment was scheduled for the following morning in order to allow family members a chance to say good bye. Throughout this time, Mr. and Mrs. Power had remained by Sean's side and were even allowed to lay next to him in his hospital bed.

On the morning of 02/27/12, the hospital social worker notified case management staff that Sean would likely not make it through the day and he was subsequently pronounced dead at 4:46 p.m.

C. Summary of Previous History. ***There are no prior reports involving this foster family.***

D. Law Enforcement Involvement/Criminal Investigation. The incident was investigated by the North Port Police Department [agency report # 2012-02-1620]. Given the circumstances surrounding Sean's death and because the medical examiner subsequently determined that the death was due to complications of an accidental drowning [see below], law enforcement closed their criminal investigation with no further action necessary.

E. Autopsy Results. Dr. Dollett T. White, Associate Medical Examiner with the District Six Medical Examiner's Office, conducted the autopsy on 02/29/12. During autopsy, Dr. White noted that Sean's body was that of a well-developed, well-nourished white male infant whose appearance was consistent with his reported age with no evidence of internal or external trauma observed upon examination. The Summary of Autopsy Findings were as follows: 1) Cerebral edema and herniation; and 2) Pneumonia. The Cause of Death was Complications of Drowning. The Manner of Death was Accident.

F. Investigative Findings. On 06/07/12, a Death Review Staffing was conducted in order to discuss the circumstances of the case as well as the investigative findings. Participants included representatives from child protective investigations, case management, and licensing. Although there had been no prior issues with regards to the Power foster home and despite their prior successes in caring for and providing stability for children in care, the inconsistent statements with regards to the level of supervision in the home were concerning, especially given that this was a licensed medical foster home where children with increased needs were placed.

This issue was further compounded by the number of children that were placed in the home at the time that the incident occurred, a total of eight. In addition to the four foster children placed in the home (ranging in ages from 6 months to 5 years), Mr. and Mrs. Power had three adoptive children (ranging in ages from 6 to 8 years), as well as Mrs. Power's older biological child (age 16 ½). Given that the Power home was licensed as a Medical Foster Home, the actual licensed capacity was set at two children. However, because they had demonstrated positive outcomes as both a

foster and adoptive family, waiver was issued to allow for additional children to be placed in the Power's home.

During the course of the investigation, additional information was obtained which prompted concerns for the level of on-going supervision in the home. Although the older children in the home initially reported that Mrs. Power would be out supervising the children whenever they were out in the swimming pool, forensic interviews conducted by the Child Protection Team yielded contradictory statements.

Initially, Mrs. Power reported that she had been in the kitchen tending to the children (e.g., getting their breakfast and medications ready). However, when interviewed, the older children in the home reported that they fixed their own breakfast while Mr. and Mrs. Power were in their bedroom. In addition, whereas Mrs. Power reported taking Sean out of his play pen and then bringing him to the bedroom, the children reported that when she took Sean out of the play pen, she just placed him down on the floor to crawl around before she returned to her bedroom where it was believed that Mr. Power was still asleep.

None of the children disclosed that they witnessed Sean crawl out of the home and fall into the swimming pool; however, they did acknowledge that once Mrs. Power started to ask where the child was that he was seen floating in the water. All acknowledged that the sliding glass door had been left open and that the pool safety fence was not secured as they forgot to close it when they finished swimming the previous day.

The children further stated that whenever they would go swimming in the pool, Mrs. Power would watch them; however, she would often be in the house reading with the back door shut.

Given the circumstances, the foster children were removed from the Power foster home and initially placed in respite care pending the outcome of the investigation. Following the forensic interviews, however, the Child Protection Team recommended that they not be returned to the Power home and that no other foster children be placed in their care.

Based on the available evidence, it was recommended that the investigation be closed with verified maltreatment findings and for the home not to be relicensed. During the staffing, Department licensing staff reported that the Powers had just been issued a denial letter and that their response to the letter was still pending.

On 06/08/12, the Institutional Report [FSFN 2012-046042 was closed with verified findings of Death due to Neglect and Inadequate Supervision with regards to Sean's death and with verified findings of Inadequate Supervision and Threatened Harm with regards to the surviving children. Both Mr. and Mrs. Power were identified as the Caregiver Responsible for all listed maltreatments. At the time of investigative closure, Safe Children Coalition was still working with the family to engage them in grief counseling services. It should be noted that just prior to the investigative staffing, the Powers had received a denial letter from the Department with regards to the relicensure of their home. Their response to the letter is still pending.

II. RECOMMENDATIONS.

This case involved the death of a 1-year-old child who drowned while he was placed in licensed foster home. There had been no prior reports involving the foster parents and nothing that would have suggested that the level of supervision in the home had become complacent. By most accounts, Mr. and Mrs. Power were described as wonderful caregivers to the children who were previously placed in their care. However, given the number of children that were residing in the

home, any reasonable person would expect that supervision issues could become challenging without appropriate provisions. Although placement options may be limited at times in any given community, it's important that all available placement options be fully explored before a waiver is sought to increase the capacity in a licensed home, and especially with regards to those tending to children with specialized needs (e.g., medical foster homes, therapeutic homes, etc.). In many cases, increased capacities result in increased stressors for otherwise reliable caregivers that may, in turn, have a negative outcome for both the provider and children in their care.

Lisa Rivera, MSW — 6/25/12
Lisa Rivera, MSW
Child Fatality Prevention Specialist
Date

Peggy Niermann — 6/25/12
Peggy Niermann
Regional QA Manager
Date

Kathy Newcomb — 6-25-12
Kathy Newcomb
Regional Program Administrator
Date

Attachments: None